THE FUTURE OF HEALTH CARE

In a follow-up to last edition's article on the Affordable Care Act, we asked some questions of two leaders in Maryland's health care profession: Gary L. Attman '79, president and CEO of FutureCare Health and Management Corporation, and Jay A. Perman, MD, president of the University of Maryland, Baltimore. Here are their thoughts.

Gary L. Attman '79

Q WHAT ARE THE IMPLICATIONS OF THE "GRAYING" OF AMERICA AND ITS EFFECTS ON THE HEALTH CARE SYSTEM?

ATTMAN: In 2012, Medicare spending was $536 billion, which accounted for 16 percent of the federal budget. Twenty-five percent of this was spent on patients in their last year of life and 40 percent of that was spent caring for those in their last month. Much of that is understandable—after all, young people don't use health care nearly as much as the elderly. And although many health care economists view this as unfair, it is important to remember that Medicare is not a poverty program but is an insurance program paid for by its beneficiaries. So the elderly have paid throughout their lives for the right to have health care services when they need them—which is often in their final days.

But there is still a problem. Because of the aging of the Baby Boomers, this quandary is getting worse. The question is how to contain health care costs at the end of life without denying compassionate care to those who have earned the right to receive such care.

There are many answers but I will propose three. First, we need to have meaningful malpractice reform. Defensive medicine has caused medical costs to skyrocket. Because of the rise in litigation, doctors and health care providers have to order every conceivable test on

GARY L. ATTMAN

As president and CEO of FutureCare Health and Management Corporation, Gary L. Attman '79 oversees all operations and strategic planning initiatives for the organization. He plays an active role in the continuous development and promotion of the FutureCare brand, as well as ongoing efforts to expand the company's facilities, technologies, service lines, and patient care programs. In 2011 and 2012, FutureCare Health was voted one of the Top Large Work Places in Maryland by *The Baltimore Sun*, and was named one of America's Top Workplaces by WorkplaceDynamics in 2013.

Prior to co-founding FutureCare Health in 1986, Mr. Attman worked as an attorney for a large law firm in the Baltimore area, and also acquired licensure as certified public accountant and real estate broker. A graduate of the University of Maryland and the School of Law, he is a member of the Maryland State Bar Association as well as various professional health care organizations, including the Health Facilities Association of Maryland (HFAM). In 2009, he was appointed by Maryland Governor Martin O'Malley to the University System of Maryland's Board of Regents.

While his roles and responsibilities are diverse, one of Mr. Attman's highest priorities is to work hands on with the members of his team, at FutureCare's headquarters as well as at each of its 12 skilled nursing and rehabilitation facilities. He is a firm believer that his company employs the best caregivers that can be found—a theory that is confirmed by the many letters of praise and gratitude he receives each week from satisfied patients and their family members.

every patient, even when common sense would suggest otherwise. Because we have a liability cap, Maryland is better than most states, but it would be very powerful if there could be limits placed on lawsuits at the federal level. Surprisingly, despite all of the legislation and rhetoric about health care there has been very little action on medical malpractice reform.

Secondly, we need to ensure that patients are treated in the most cost effective setting. Most patients would prefer to be at home and, with the advent of sophisticated home care and telemedicine, patients can now be offered high quality (and relatively inexpensive) care at home. For patients who cannot be cared for at home we have many excellent hospitals throughout Maryland. But patients should be encouraged to transfer to post-acute facilities (primarily skilled nursing and rehabilitation facilities) as soon as possible after a hospitalization. Or, in many cases, post-acute facilities can treat the patient without a hospital stay. Hospitals are absolutely necessary for emergency and surgical care but an ecosystem of post-acute facilities and services has evolved that can perform many other services that were once performed in hospitals, including ventilator care, cardiac rehabilitation, physical therapy, chemotherapy, and many others. Generally these services can be provided by skilled nursing facilities at a fraction of the cost of hospital services with excellent patient outcomes.

Finally, it is important for physicians and families (as well as patients, of course) to have sensitive but frank discussions about end-of-life care. In many cases it is not in the interest of the patient or the family to suffer through another surgery or another round of chemo. It might be better for all to work with the caregivers to minimize the patient's pain and to enable a peaceful passing with maximum patient dignity. This not only controls cost—it is the right thing to do.

PERMAN: We need to take a critical look at our national commitment to health and wellness in ensuring that our "gray" years are really "golden" years. I certainly agree that we must meet our obligations to robust health care for the elderly. But are we doing enough to increase the likelihood that we will arrive at that stage of life in the best shape possible, and thus reduce the burden of illness which our health care system must manage?

I think we, as a nation, could do more. We could step up our efforts to promote and incentivize healthy lifestyles. We could better support healthier eating. We could make our environments more

Jay A. Perman, MD

JAY A. PERMAN, MD

Jay A. Perman, MD, was appointed president of the University of Maryland, Baltimore (UMB) in July 2010. A pediatric gastroenterologist, Dr. Perman continues to practice medicine through his weekly President's Clinic, where he teaches team-based health care to students of medicine, pharmacy, nursing, dentistry, social work, and law while treating pediatric patients.

Dr. Perman received a Doctor of Medicine degree, with distinction, in 1972 from Northwestern University. Following his residency in pediatrics at Northwestern University Children's Memorial Hospital in Chicago in 1975, he completed a fellowship in pediatric gastroenterology at Harvard Medical School and at the Children's Hospital Medical Center in Boston in 1977. At the UMB campus, he chaired the Department of Pediatrics in the School of Medicine from 1999 to 2004. He served as dean and vice president for clinical affairs at the University of Kentucky (UK) College of Medicine from 2004 to 2010.

Dr. Perman's long and distinguished career includes service on many national, state, and local organizations, boards, and committees. While at UK, he received the President's Award for Diversity and the Public Health Hero Award from the Lexington-Fayette Urban County government, and he has been listed among The Best Doctors in America since 2001. He is a past president of the North American Society for Pediatric Gastroenterology and Nutrition, a former section chair of the American Gastroenterological Association, and a former Executive Committee member of the American Academy of Pediatrics. Dr. Perman also currently serves as chairman of the Board of Directors for the Greater Baltimore Committee and is a member of the Board of Directors of the Hippodrome Foundation, and the Downtown Partnership.

walkable and conducive to bike riding. We could educate better against the abuse of substances that we know leads to debilitating, costly diseases later in life. Here at UMB we have created the Institute for a Healthiest Maryland to take action to address these issues. All these things take our collective will. And they take money.

Our nation must be willing to invest. We need to reimburse physicians and other health care providers who today are not paid to take the extra few minutes it requires to do some preventive medicine in the office. Are we going to invest now so that we can have cost avoidance later, in human terms, and in how we spend the health care dollar? If we are to truly grow old gracefully and die of "old age," we need to rebalance our health care system and our investments to provide the very best care for disease and dysfunction in our later years while maximizing efforts to reduce the overall degree of suffering once we reach those years.

Q HOW IS THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT GOING TO AFFECT THE WAY HEALTH CARE PROFESSIONALS ARE EDUCATED?

PERMAN: The implications on education are probably yet to be defined. That said, the likely expansion of care to many more individuals than currently have access to health care, and the fact that among them are many with chronic diseases, probably requires us to accelerate the way in which we teach health care professionals to work in teams. I say that from several perspectives. The addition of many more individuals who will be covered and who will demand access to health care will strain the number of professionals currently available to provide health care. I am speaking particularly of physicians and nurse practitioners. To the extent that we can educate health care providers across the professional spectrum to work in teams, we may be able to meet the burden. For example, we need to understand the roles that pharmacists can play beyond the current foci they have. We could say the same about dentists, dental hygienists, social workers, physical therapists, nutritionists, and many other members of the health care professions. All can play a part if they work as a team in expanding our ability to cover the many who are newly enfranchised in requiring health care.

Secondly, it is predictable that many who have not been covered will come to the health care arena with chronic diseases. There is an emerging literature that supports the use of a team-based approach in providing care to these populations.

In summary, I think that the advent of the Affordable Care Act will probably place increasing requirements on educators to prepare a team-oriented workforce. I am happy to say that we have made a commitment to do so here at UMB.

Q HOW HAS TECHNOLOGY CHANGED THE DELIVERY OF MEDICAL SERVICES ACROSS DIFFERENT PLATFORMS?

ATTMAN: Our company uses technology extensively for charting and measuring patient progress and coordinating with the treatment team, both in and out of our skilled nursing facilities. We are implementing electronic medical records and offer a wireless environment that is compatible with a variety of platforms so our clinical team can always keep tabs on the progress of our patients.

In terms of treatments, the latest technology has greatly assisted us in providing effective treatment to our patients so that they can return home more quickly. People think of nursing homes as a one-way street, but at FutureCare's skilled nursing facilities, nearly 90 percent of our admitted patients return home substantially rehabilitated within 30 days of admission. Our therapists use a variety of innovative modalities, including virtual reality devices for balance and gait, vital stim technology to treat swallowing difficulties, and diathermy therapy for non-pharmacological pain management; and we can confirm the correct placement of peripherally inserted central catheters at the bedside, thus eliminating the historical need for a hospital transfer. We are always on the lookout for newer and better technologies to help our patients.

PERMAN: We have made extraordinary advances, particularly over the last three decades, in the technologies we can apply to patients' health care. We can open vessels that devastate us when they close; we can identify disease and injury through imaging modalities that were unimaginable in my early years of practice; and we can record individual health-related data and analyze aggregated data across populations so we can provide even better health care.

In fact, the University of Maryland, Baltimore is in the forefront of the discoveries that make advanced biomedical technology possible. That said, some cautionary notes are appropriate so that we avoid creating "negatives" out of "positives." Each time a technological innovation comes along, we must critically assess whether it makes a meaningful difference in our care of patients. Does it change outcomes? We must be careful not to overuse new

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and exciting technologies just because we can. For example, excessive use of imaging studies may have long-term health consequences such as undesired effects of radiation. Unnecessary imaging sometimes uncovers findings of questionable import; yet the physician then feels an obligation to investigate more, and a vicious, expensive cycle ensues.

Similarly, our use of electronic medical records is a critically important development. This technology will help us to truly link health care providers across locations into well-functioning teams. And electronic medical records will assist in preventing unnecessary tests that are repeated simply because recent results obtained elsewhere are not available to the provider seeing you at the moment. Once again, though, we must guard against undesirable consequences. I am concerned that the entry of electronic information during a patient visit may threaten the importance of face-to-face verbal and non-verbal communication between provider and patient. The computer must not be a distraction or impede that communication.

So once again, we need to balance the incredible power we have through technology with a recognition of potential undesirable effects. I am confident that we can achieve such balance as we provide the most outstanding health care possible.

Q AS THE DIAGNOSIS OF DISEASES BECOMES MORE COMPLICATED, HOW CAN LAWYERS AND HEALTH CARE PROFESSIONALS PARTNER TO ADDRESS ISSUES IN THE PROVISION OF HEALTH CARE, ESPECIALLY TO UNDERREPRESENTED POPULATIONS?

ATTMAN: One major reason diagnoses and patient co-morbidities are becoming more complicated is because we are living longer and dealing with situations we have never experienced before. Historically, patients didn’t live long enough to get Alzheimer’s, or diabetes and/or renal failure, etc. These co-morbidities create a situation in which patients, especially the elderly, are presenting with incredibly complex conditions. One way that lawyers and health care professionals can partner is for an increased and ongoing focus on educating and assisting the patient to execute clear and meaningful advanced directives and/or appoint health care agents. This has and will continue to be an imperative aspect of health care delivery—allowing people to clearly communicate how they want to direct their care. There has been some movement in this area, but not nearly enough health care professionals understand this important aspect and I see a great opportunity for the legal/health care communities to make great strides here. This has even greater significance for underserved areas.

Also, with the ACA and changes in Medicare, Medicaid, etc. there are significant opportunities for lawyers to teach the health care community and the public how these laws affect health care and how patients can access health care under the law. For example, a few months ago Holly O’Shea, our VP and Corporate Counsel, taught an upper-level BSN nursing class at Hood College on the ACA. This is a perfect example of the potential for collaboration.

PERMAN: Lawyers, in my mind, are often critically important to the delivery of health care. What do I mean by that? It’s often not so much a challenge of diagnosis and treatment of a specific chronic disease as much as it’s the influence of the environment in which that patient lives that challenges us. What we are talking about here is an area that we call the social determinants of health. I often like to use a pediatric example. In cities with old housing, small children are at risk for lead poisoning. We are reasonably skilled at diagnosing and treating lead poisoning. Unfortunately, what we need to keep in mind is that the treatment of that child is not completed by straightforward diagnosis and treatment. A failure to adjust the environment of the child will result in a recurrence of the lead poisoning. Changing the environment is often a matter of getting property owners to comply with the law. You therefore need a lawyer on the health care team in caring for a child and family like this.

Increasingly, we need the development and expansion of medical/legal partnerships to address the social determinants of health. Law students are an integral part of UMB’s interprofessional health care education care programs. ■